

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
HUMIRA (adalimumab) for Ulcerative Colitis

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Age requirement: 18 years and older
- Diagnosis of moderate to severe Ulcerative Colitis
- Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Humira may not be given with other biologic agents such as Interferon, experimental medications or combination.
- Documented inadequate response or contraindication to steroid therapy. Please describe the dose(s) tried and any titrations performed.
 - Prednisone (oral) OR hydrocortisone (enema and/or foam)
- Documented inadequate response or contraindication to 5-aminosalicylic acid derivative therapy. Please describe the dose(s) tried and any titrations performed.
 - Balsalazide (oral) OR mesalamine (oral, enema or suppository) OR olsalazine (oral) OR sulfasalazine (oral)

AUTHORIZATION:

1 year

Initial prior is for one 6-syringe Crohn's starter pack and 2-syringe maintenance packs monthly thereafter (a Crohn's starter pack is appropriate because treatment initiation for Ulcerative Colitis and for Crohn's is the same).

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement with medication.

07/03/2013

<http://health.utah.gov/medicaid/pharmacy>